AMENDED IN SENATE JUNE 12, 2006

AMENDED IN ASSEMBLY MAY 2, 2006

AMENDED IN ASSEMBLY APRIL 6, 2006

CALIFORNIA LEGISLATURE—2005–06 REGULAR SESSION

ASSEMBLY BILL No. 2889

Introduced by Assembly Member Frommer

February 24, 2006

An act to ~~amend Section 1366.35 of~~ *add Section 1374.18 to* the Health and Safety Code, and to ~~amend Section 10785 of~~ *add Section 10119.1 to* the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2889, as amended, Frommer. Health care coverage: ~~federally eligible defined~~ individual *market*.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health care service plan and a health insurer are ~~prohibited from declining to cover or enroll a federally eligible defined individual, except as specified, and are also prohibited from imposing a preexisting condition exclusion with respect to such a person. Existing law defines a federally eligible defined individual, in part, as an individual who has had 18 months of creditable coverage, with the most recent coverage being under a group plan or specified governmental or church plan~~ *required to include specified coverage provisions in their plan contracts and policies*.

This bill would ~~expand the definition of a federally eligible defined individual to include an individual who has had 18 months of creditable coverage, with the most recent coverage being under an individual health plan, as specified~~ *require a health care service plan and a health insurer to permit an individual who has been covered for at least 18 months under an individual plan contract issued by the health care service plan or an individual health benefit plan issued by the insurer to transfer, without medical underwriting, as defined, to another individual plan contract or individual health benefit plan having an equal or greater share-of-cost offered by the health care service plan or insurer*.

Because the bill~~, by expanding this definition, would prohibit a plan from denying coverage or enrollment to a larger group of persons, it would make additional conduct unlawful~~ *would specify additional requirements* under the Knox-Keene Act,~~ thereby imposing~~ *the violation of which could be a crime, it would impose* a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1374.18 is added to the Health and Safety Code, to read:

1374.18. (a) This section shall apply to a health care service plan that provides coverage under an individual plan contract that is issued, amended, delivered, or renewed on or after January 1, 2007.

(b) The health care service plan shall permit an individual who has been covered for at least 18 months under an individual plan contract to transfer, without medical underwriting, as defined in subdivision (c), to any other individual plan contract offered by that same health care service plan that provides equal or lesser benefits, as defined in subdivision (c).

(c) The following definitions apply for the purposes of this section:

(1) "Equal or lesser benefits" means that the new individual plan contract requires an equal or greater share-of-cost from the individual than the individual plan contract from which the individual transferred.

(2) "Without medical underwriting" means that the health care service plan shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual.

SEC. 2. Section 10119.1 is added to the Insurance Code, to read:

10119.1. (a) This section shall apply to a health insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan, as defined in subdivision (a) of Section 10198.6, that is issued, amended, renewed, or delivered on or after January 1, 2007.

(b) A health insurer shall permit an individual who has been covered for at least 18 months under an individual health benefit plan to transfer, without medical underwriting, as defined in subdivision (c), to any other individual health benefit plan offered by that same health insurer that provides equal or lesser benefits, as defined in subdivision (c).

(c) The following definitions apply for the purposes of this section:

(1) "Equal or lesser benefits" means that the new individual health benefit plan requires an equal or greater share-of-cost from the individual than the individual health benefit plan from which the individual transferred.

(2) "Without medical underwriting" means that the health insurer shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual.

~~SECTION 1. Section 1366.35 of the Health and Safety Code is amended to read:~~

~~1366.35. (a) A health care service plan providing coverage for hospital, medical, or surgical benefits under an individual health care service plan contract may not, with respect to a federally eligible defined individual desiring to enroll in individual health insurance coverage, decline to offer coverage~~

~~to, or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.~~

~~(b) For purposes of this section, "federally eligible defined individual" means an individual who, as of the date on which the individual seeks coverage under this section, meets all of the following conditions:~~

~~(1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group or individual health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002). For the purposes of this paragraph, an individual health plan shall not include vision only, dental only, accident only, specified disease, hospital indemnity, Medicare supplement, CHAMPUS supplement, long-term care, a contract or arrangement that provides access to discounted or reduced rates for health care services or providers but the individual retains responsibility for full payment of the discounted rates, or disability income insurance.~~

~~(2) Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage.~~

~~(3) Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud.~~

~~(4) If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.~~

~~(c) Every health care service plan shall comply with applicable federal statutes and regulations regarding the provision of coverage to federally eligible defined individuals, including any relevant application periods.~~

~~(d) A health care service plan shall offer the following health benefit plan contracts under this section that are designed for, made generally available to, are actively marketed to, and enroll, individuals: (1) either the two most popular products as defined in Section 300gg-41(c)(2) of Title 42 of the United States Code and Section 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2) the two most representative products as defined in Section 300gg-41(c)(3) of the United States Code and Section 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as determined by the plan in compliance with~~

~~federal law. A health care service plan that offers only one health benefit plan contract to individuals, excluding health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this article if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this article.~~

~~(e) (1) In the case of a health care service plan that offers health insurance coverage in the individual market through a network plan, the plan may do both of the following:~~

~~(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.~~

~~(B) Within the service area of the plan, deny coverage to individuals if the plan has demonstrated to the director that the plan will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contractholders and enrollees and individual enrollees, and that the plan is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.~~

~~(2) A health care service plan, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer coverage in the individual market within that service area for a period of 180 days after the coverage is denied.~~

~~(f) (1) A health care service plan may deny health insurance coverage in the individual market to a federally eligible defined individual if the plan has demonstrated to the director both of the following:~~

~~(A) The plan does not have the financial reserves necessary to underwrite additional coverage.~~

~~(B) The plan is applying this subdivision uniformly to all individuals in the individual market and without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.~~

~~(2) A health care service plan, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual~~

~~market within that service area for a period of 180 days after the date the coverage is denied or until the issuer has demonstrated to the director that the plan has sufficient financial reserves to underwrite additional coverage, whichever is later.~~

~~(g) The requirement pursuant to federal law to furnish a certificate of creditable coverage shall apply to health insurance coverage offered by a health care service plan in the individual market in the same manner as it applies to a health care service plan in connection with a group health benefit plan.~~

~~(h) A health care service plan shall compensate a life agent or fire and casualty broker-agent whose activities result in the enrollment of federally eligible defined individuals in the same manner and consistent with the renewal commission amounts as the plan compensates life agents or fire and casualty broker-agents for other enrollees who are not federally eligible defined individuals and who are purchasing the same individual health benefit plan contract.~~

~~(i) Every health care service plan shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the Health Insurance Portability and Accountability Act of 1996, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits in order to become a federally eligible defined individual.~~

~~(j) No health care service plan may request documentation as to whether or not a person is a federally eligible defined individual other than is permitted under applicable federal law or regulations.~~

~~(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.~~

~~*(l)* This section shall apply to health care service plan contracts offered, delivered, amended, or renewed on or after January 1, 2001.~~

~~SEC. 2. Section 10785 of the Insurance Code is amended to read:~~

~~10785. (a) A health insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan as defined in subdivision (a) of Section 10198.6 may not, with respect to a federally eligible defined individual desiring to enroll~~

~~in individual health insurance coverage, decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.~~

~~(b) For purposes of this section, "federally eligible defined individual" means an individual who, as of the date on which the individual seeks coverage under this section, meets all of the following conditions:~~

~~(1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group or individual health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002). For the purposes of this paragraph, an individual health plan shall not include vision only, dental only, accident only, specified disease, hospital indemnity, Medicare supplement, CHAMPUS supplement, long-term care, a contract or arrangement that provides access to discounted or reduced rates for health care services or providers but the individual retains responsibility for full payment of the discounted rates, or disability income insurance.~~

~~(2) Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage.~~

~~(3) Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud.~~

~~(4) If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.~~

~~(c) Every health insurer that covers hospital, medical, or surgical expenses shall comply with applicable federal statutes and regulations regarding the provision of coverage to federally eligible defined individuals, including any relevant application periods.~~

~~(d) A health insurer shall offer the following health benefit plans under this section that are designed for, made generally available to, are actively marketed to, and enroll, individuals: (1) either the two most popular products as defined in Section 300gg-41(c)(2) of Title 42 of the United States Code and Section 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2) the two most representative products as defined in Section 300gg-41(c)(3) of the United States Code and Section~~

~~148.120(c)(3) of Title 45 of the Code of Federal Regulations, as determined by the insurer in compliance with federal law. An insurer that offers only one health benefit plan to individuals, excluding health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this chapter if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this chapter.~~

~~(e) (1) In the case of a health insurer that offers health benefit plans in the individual market through a network plan, the insurer may do both of the following:~~

~~(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.~~

~~(B) Within the service area covered by the health benefit plan, deny coverage to individuals if the insurer has demonstrated to the commissioner that the insured will not have the capacity to deliver services adequately to additional individual insureds because of its obligations to existing group policyholders, group contractholders and insureds, and individual insureds, and that the insurer is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.~~

~~(2) A health insurer, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer health benefit plans through a network in the individual market within that service area for a period of 180 days after the coverage is denied.~~

~~(f) (1) A health insurer may deny health insurance coverage in the individual market to a federally eligible defined individual if the insurer has demonstrated to the commissioner both of the following:~~

~~(A) The insurer does not have the financial reserves necessary to underwrite additional coverage.~~

~~(B) The insurer is applying this subdivision uniformly to all individuals in the individual market and without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.~~

~~(2) A health insurer, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual market within that service area for a period of 180 days after the date the coverage is denied or until the insurer has demonstrated to the commissioner that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.~~

~~(g) The requirement pursuant to federal law to furnish a certificate of creditable coverage shall apply to health benefit plans offered by a health insurer in the individual market in the same manner as it applies to an insurer in connection with a group health benefit plan policy or group health benefit plan contract.~~

~~(h) A health insurer shall compensate a life agent or fire and casualty broker-agent whose activities result in the enrollment of federally eligible defined individuals in the same manner and consistent with the renewal commission amounts as the insurer compensates life agents or fire and casualty broker-agents for other enrollees who are not federally eligible defined individuals and who are purchasing the same individual health benefit plan.~~

~~(i) Every health insurer shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the Health Insurance Portability and Accountability Act of 1996, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits in order to become a federally eligible defined individual.~~

~~(j) No health insurer may request documentation as to whether or not a person is a federally eligible defined individual other than is permitted under applicable federal law or regulations.~~

~~(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.~~

~~(*l*) This section shall apply to policies or contracts offered, delivered, amended, or renewed on or after January 1, 2001.~~

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the

penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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